25th Multidisciplinary Management of Cancers: A Case-Based Approach

Supportive Oncology & Survivorship

Friday, March 7, 2025
3:30PM

Stanford Cancer Institute cancer.stanford.edu | Stanford Medicine | UC Davis Health | UCSF Comprehensive Cancer Center | Helen Diller Family Comprehensive Cancer Center | ANCO Educating and Empowering the Northern California Cancer Community

1

1

25th Multidisciplinary Management of Cancers: A Case-Based Approach

ACCREDITATION

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of i3 Health and ANCO. In support of improving patient care, this activity has been planned and implemented by i3 Health and ANCO. i3 Health is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Physicians: i3 Health designates this live activity 15 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Physician Assistants: Physician Assistants, American Academy of Physician Assistants (AAPA) accepts certificates of participation for educational activities approved for *AMA PRA Category 1 Credit*™ from organizations accredited by ACCME. Physician assistants may receive a maximum of 15 hours of Category 1 credit for completing this program.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 15 Medical Knowledge MOC points in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program.

Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit. By providing this information, participants are agreeing to allow i3 Health to share this information with the ACCME.

INSTRUCTIONS TO RECEIVE CREDIT

An activity evaluation form will be distributed. To claim credit, you must fill out and submit the form at the conclusion of the program. Your certificate of attendance will either be mailed or emailed to you after your evaluations have been reviewed.

UNAPPROVED USE DISCLOSURE

This educational activity may contain discussion of published and/or investigational uses of agents that are not indicated by the FDA. The planners of this activity do not recommend the use of any agent outside of the labeled indications.

The opinions expressed in the educational activity are those of the faculty and do not necessarily represent the views of the planners. Please refer to the official prescribing information for each product for discussion of approved indications, contraindications, and warnings.

DISCLAIMER

The information provided at this CME activity is for continuing education purposes only and is not meant to substitute for the independent medical/clinical judgment of a healthcare provider relative to diagnostic and treatment options of a specific patient's medical condition.

Stanford Cancer Institute cancer.stanford.edu | Stanford Medicine | UC Davis Health | UCSF Comprehensive Cancer Center | Helen Diller Family Comprehensive Cancer Center | ANCO Educating and Empowering the Northern California Cancer Community

2

2

25th Multidisciplinary Management of Cancers: A Case-Based Approach

Panelists

Surbhi Singhal, MD, UC Davis - Chair
Chloe Lalonde, MD, UC Davis - Fellow, Case Presenter

Medical Oncology
Milana Dolezal, MD, Stanford
Sara Keck, MD, Providence Medical Group
Kavitha Ramchandran, MD, Stanford
Lidia Schapira, MD, Stanford
Anjali Sibley, MD, Stanford

Palliative Care and Supportive Oncology
Ayana Davis, RD, UCSF
Alex Fauer, PhD, UC Davis
Angela Laffan, NP, UCSF
Mike Rabow, MD, UCSF

Stanford Cancer Institute cancer.stanford.edu Stanford Medicine | UC DAVIS HEALTH COMPREHENSIVE CANCER CENTER | UCSF Helen Diller Family Comprehensive Cancer Center | ANCO Educating and Empowering the Northern California Cancer Community

3

25th Multidisciplinary Management of Cancers: A Case-based Approach

Disclosures

Full Name	Role	Type of Financial Relationship	Company
Surbhi Singhal	**Chair**	Advisory Board or Panel	Caris and Oncohost
Chloe Sidney Broome Lalonde	**Fellow**	Disclosed no relevant financial relationships.	
Ayana Davis	Panelist	Disclosed no relevant financial relationships.	
Milana Dolezal	Panelist	Advisory Board or Panel	AstraZeneca (once in 2024), Gilead (once in 2025)
Alex Fauer	Panelist	Disclosed no relevant financial relationships.	
Sara Keck	Panelist	Disclosed no relevant financial relationships.	
Angela Laffan	Panelist	Disclosed no relevant financial relationships.	
Mike Rabow	Panelist	Disclosed no relevant financial relationships.	
Kavitha Ramchandran	Panelist	Disclosed no relevant financial relationships.	
Lidia Schapira	Panelist	Disclosed no relevant financial relationships.	
Anjali Sibley	Panelist	Grants/Research Support	Stanford Cancer Institute

UCSF Helen Diller Family Comprehensive Cancer Center | Stanford Cancer Institute cancer.stanford.edu Stanford Medicine | UC DAVIS HEALTH COMPREHENSIVE CANCER CENTER | ANCO Educating and Empowering the Northern California Cancer Community

ANCO and i3 Health have mitigated all relevant financial relationships.

4

Case 1 – 67-year-old man with Stage IIB NSCLC

Incidentally found to have RLL lung nodule

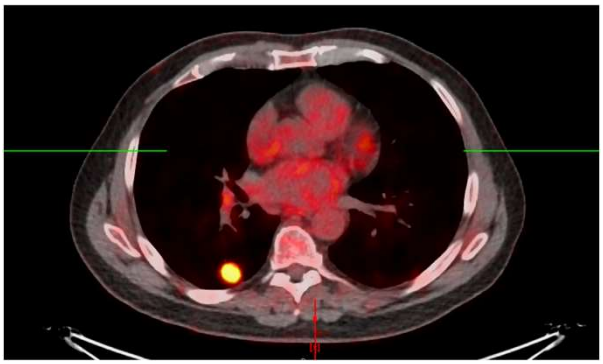
Dx: NSCLC, adenocarcinoma, KRAS G12C+

Tx: S/p lobectomy and mediastinal lymph node dissection, final staging **pT2aN1 (Stage IIB)**

Performance status: ECOG 1

Past medical history: hearing loss from prior construction work

Social history: former tobacco use (30 pack years), lives with wife and good family support



SOC therapy: adjuvant platinum/pemetrexed followed by immune checkpoint inhibitor

5

Case 1 – 67-year-old man who completed NSCLC treatment

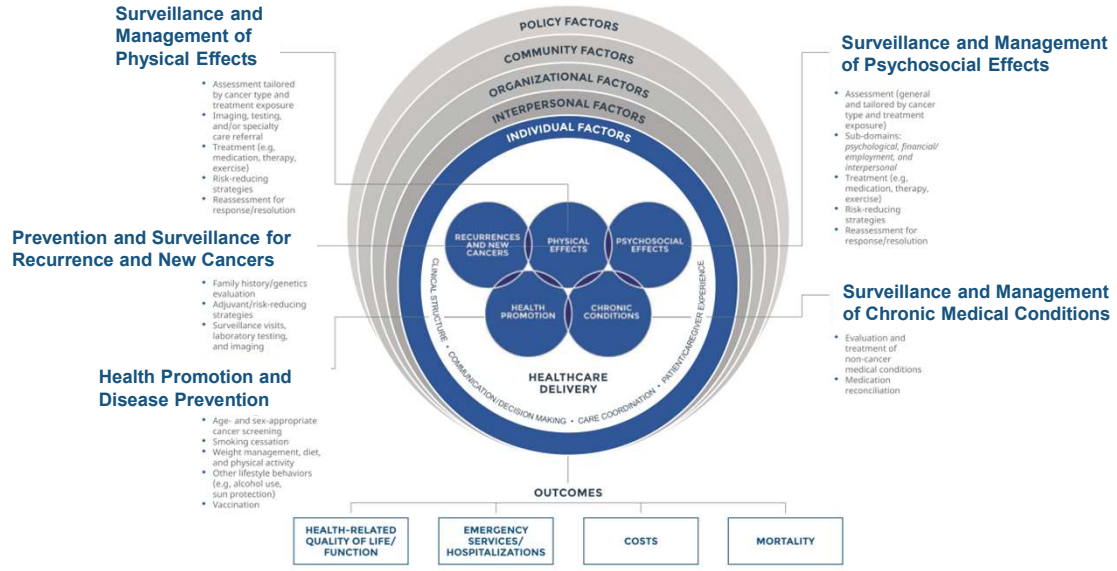
Patient completes adjuvant platinum/pemetrexed followed by immune checkpoint inhibitor. Treatment largely uncomplicated, except patient reports new memory loss.

Question 1: In this 67-year-old man, ECOG 1, who has completed lung cancer treatment, who would you expect to perform the ongoing cancer survivorship care?

1. Cancer survivorship clinic
2. Geriatrics
3. Medical oncology
4. Palliative care
5. Primary care

6

A Quality of Cancer Survivorship Care Framework



Nekhyludov et al., JNCI, 2019

7

7

Case 1 – 67-year-old man who completed NSCLC treatment

Question 2: In this 67-year-old man who is reporting new memory loss after completion of cancer treatment, what would you recommend next?

1. Brain MRI
2. Formal neuropsychiatric testing
3. Mini cognitive assessment in clinic
4. Neurology evaluation
5. Trial of donepezil

8

8

Case 1 – 67-year-old man who completed NSCLC treatment

The patient undergoes brain MRI that shows no evidence of disease. He is referred for formal neuropsychiatric testing and awaiting his appointment. He starts donepezil with mild improvement in his symptoms. His scans continue to show no evidence of disease recurrence.

Take Home Messages

Cancer survivorship care is multifaceted and includes management of chronic effects from cancer treatment, evaluation for disease recurrence and secondary cancers, management of chronic medical conditions, and management of psychosocial conditions.

25th Multidisciplinary Management of Cancers: A Case-Based Approach

Case 2 – 56-year-old man with thymic carcinoma

He presents to a local hospital with 6 months of progressive chest pain, fatigue, and **unintentional weight loss**, found to have large mediastinal mass, and is diagnosed with thymic carcinoma.

Tumor board: not surgical candidate due to vessel involvement

Started on concurrent weekly carboplatin/paclitaxel with radiation

At his follow up visit 2 weeks into treatment, noted to have further weight loss (additional 5% of body weight). Upon further questioning, he reports poor appetite.

Case 2 – 56-year-old man with thymic carcinoma

Patient is recommended to start Ensure supplementation. At his follow up visit in 2 weeks, he has lost additional weight.

Question 1: Which diagnosis would you apply for this patient with ~10% unintentional weight loss and fatigue?

1. Normal cancer process
2. Unintentional weight loss
3. Pre-cachexia
4. Cancer cachexia
5. Refractory cachexia

11

Case 2 – 56-year-old man with thymic carcinoma

He is evaluated by RD, recommended additional oral supplementation, and his weight loss stabilizes by the end of treatment.

14 months later, he re-presents with progressive severe chest pain, fatigue, and weight loss. Found to have **biopsy proven disease recurrence** with metastases to liver and bone.

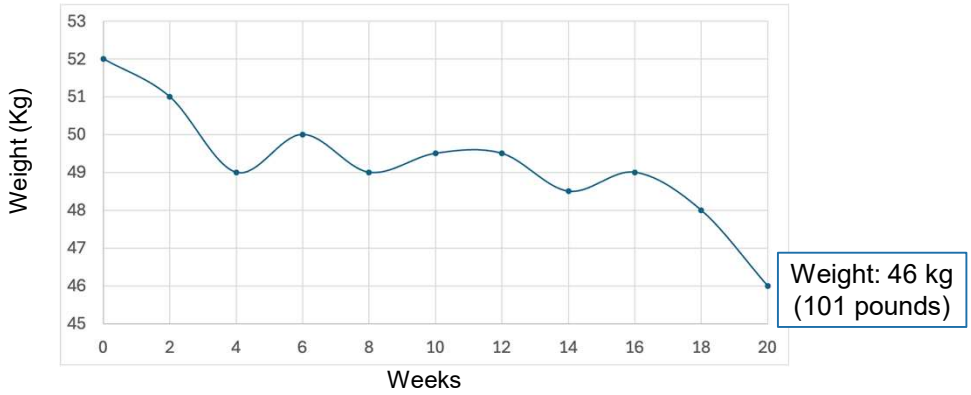
Developed progressive disease after 3 cycles of carboplatin/paclitaxel. ECOG performance status (PS) now 2.

Starts on 2L gemcitabine monotherapy with plan to add capecitabine pending PS.

12

Case 2 – 56-year-old man with thymic carcinoma

Continuing to work with RD and increase oral supplementation, but ongoing weight loss.



Case 2 – 56-year-old man with thymic carcinoma

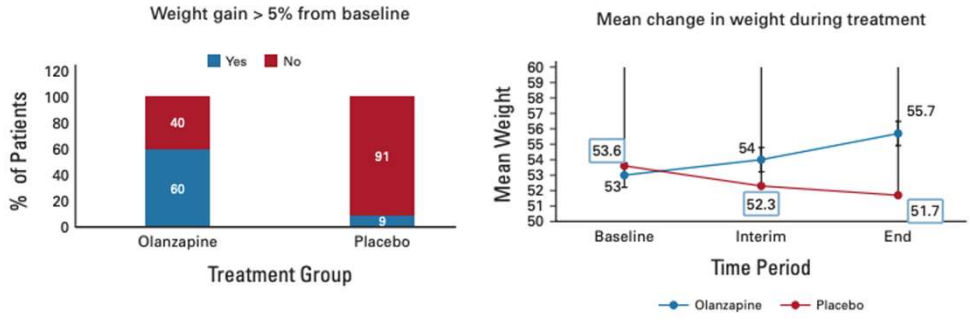
Question 2: What would you recommend for this patient with cancer cachexia on palliative intent 2L chemotherapy?

1. Cannabinoid
2. Dexamethasone
3. Olanzapine
4. Progesterone analog
5. Referral for G tube

25th Multidisciplinary Management of Cancers: A Case-Based Approach

Olanzapine during chemotherapy can improve weight gain, appetite, and chemotherapy-induced nausea.

RCT of olanzapine versus placebo among patients starting palliative-intent chemotherapy for gastric, HPB, and lung Cancer



Sandhya et al., JCO, 2023

15

25th Multidisciplinary Management of Cancers: A Case-Based Approach

Case 2 – 56-year-old man with thymic carcinoma

The patient is prescribed oral dexamethasone and starts using cannabis for both appetite stimulation and sleep. He continues to lose weight, repeat scans show further progression, and he elects for hospice.

Take Home Messages

- **Olanzapine** can improve weight gain and appetite for patients receiving chemotherapy
- **Early RD referral** for patients at risk for developing cancer cachexia

Stanford Cancer Institute | UC DAVIS HEALTH | UCSF COMPREHENSIVE CANCER CENTER | Helen Diller Family Comprehensive Cancer Center | ANCO

16

16

25th Multidisciplinary Management of Cancers: A Case-Based Approach

Case 3 – 28F with breast cancer

Presents with 6 cm left breast lower inner quadrant mass

Pathology: invasive ductal carcinoma, ER positive (91-100%), PR positive (21-30%), HER2 2+ by IHC, FISH negative

Staging: Left axilla clinically node negative, no suspicious nodes on MRI breast or CT chest

Genetic testing: Negative 26-gene panel for pathogenic mutations

Treatment recommendation: Evaluated by surgical and medical oncology and recommended to start **neoadjuvant chemotherapy** for Stage IIB (cT3N0M0) breast cancer

Social history: She is married and has no children

Stanford Cancer Institute | UC DAVIS HEALTH | UCSF COMPREHENSIVE CANCER CENTER | Helen Diller Family Comprehensive Cancer Center | ANCO

17

17

25th Multidisciplinary Management of Cancers: A Case-Based Approach

Case 3 – 28F with breast cancer

Question 1: What would you recommend regarding fertility preservation for this young woman starting curative intent chemotherapy for stage IIB breast cancer?

1. No additional recommendations, proceed with neoadjuvant chemotherapy
2. Referral for egg retrieval
3. Referral to AYA specialist
4. Start leuprolide ovarian suppression

Stanford Cancer Institute | UC DAVIS HEALTH | UCSF COMPREHENSIVE CANCER CENTER | Helen Diller Family Comprehensive Cancer Center | ANCO

18

18

Case 3 – 28F with breast cancer

She receives ovarian suppression and completes neoadjuvant chemotherapy with excellent response.

She undergoes a left skin-sparing mastectomy and SLNB, which reveals minimal residual invasive mammary carcinoma (pT1bN0). She is **started on tamoxifen 20 mg PO daily** and continues on leuprolide.

During follow-up, she reports difficulty with sexual intercourse. On further questioning, you learn she has vaginal dryness.

19

25th Multidisciplinary Management of Cancers: A Case-Based Approach

Case 3 – 28F with breast cancer

Question 2: What would you recommend for this young woman on endocrine therapy who is experiencing sexual dysfunction?

1. Referral to OB/GYN
2. Referral to patient support group
3. Referral to physical therapy for pelvic floor disorder
4. Referral to primary care
5. Topical estrogen
6. Topical lubricant

20

25th Multidisciplinary Management of Cancers: A Case-Based Approach

Sexual dysfunction is common among women with breast cancer.

SOFT/TEXT Trials among Pre-Menopausal Women

Adverse Event	Tamoxifen (N=1005)		Tamoxifen plus Ovarian Suppression (N=2326)		Exemestane plus Ovarian Suppression (N=2317)	
	Any Event	Grade 3 or 4 Event	Any Event	Grade 3 or 4 Event	Any Event	Grade 3 or 4 Event
	number of patients (percent)					
Any targeted adverse event	962 (95.7)	247 (24.6)	2295 (98.7)	721 (31.0)	2288 (98.7)	748 (32.3)
Hot flushes	808 (80.4)	78 (7.8)	2175 (93.5)	284 (12.2)	2141 (92.4)	234 (10.1)
Depression	476 (47.4)	41 (4.1)	1195 (51.4)	108 (4.6)	1197 (51.7)	95 (4.1)
Sweating	492 (49.0)	NA	1391 (59.8)	NA	1286 (55.5)	NA
Vaginal dryness	426 (42.4)	NA	1144 (49.2)	NA	1245 (53.7)	NA
Decreased libido	434 (43.2)	NA	981 (42.2)	NA	1056 (45.6)	NA
Dyspareunia	242 (24.1)	16 (1.6)	636 (27.3)	35 (1.5)	733 (31.6)	56 (2.4)
Urinary incontinence	166 (16.5)	6 (0.6)	433 (18.6)	9 (0.4)	317 (13.7)	9 (0.4)

Francis et al., NEJM, 2018

Cohort Study: No evidence of increase in breast-cancer specific mortality with vaginal estrogen

Analysis	No. of events	Person-years	Adjusted HR (95% CI)[a]	*P* value
Pooled				
No HRT	5624	285 342	1 [Reference]	NA
Systemic HRT	51	3894	0.90 (0.63-1.28)	.56
Only vaginal estrogen therapy	120	11437	0.72 (0.60-0.86)	<.001
1-4 Vaginal estrogen therapy prescriptions	105	9374	0.75 (0.62-0.92)	.005
≥5 Vaginal estrogen therapy prescriptions	15	2062	0.55 (0.32-0.97)	.04
Lower-dose vaginal estrogen therapy	92-97[c]	9098	0.71 (0.55-0.93)	.01
Higher-dose vaginal estrogen therapy[d]	23-28[c]	2339	0.78 (0.53-1.15)	.22

McVicker et al., JAMA Oncology 2024

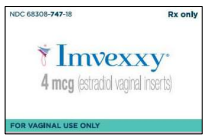
It is recommended that there be a discussion with the patient, initiated by a member of the health-care team, regarding sexual health and dysfunction resulting from cancer or its treatment. -- ASCO guidelines

21

25th Multidisciplinary Management of Cancers: A Case-Based Approach

Common Sexual Health Problems	Summary of Potential Interventions
Genital symptoms • Including symptoms of VVA (vaginal dryness, irritation, soreness, and pain, as well as urinary frequency, urgency, and incontinence) **What is the biggest barrier?** No pain with intercourse? **When/where does this barrier actually occur?** At the start with penetration only? **When a barrier occurs how do we get you back?**	• Vaginal moisturizers and lubricants • Skin sealants and protectants • Hormone therapies (low-dose vaginal estrogen) • Lidocaine (topical) and pain relievers • Dilator therapy/Vibrators • Pelvic floor therapy • Cognitive behavioral therapy • Vaginal laser therapy
Vasomotor symptoms • Hot flashes and night sweats/sleep interference	Medication review, ETOH use, teaspoon of peanut butter at night (hypoglycemia…) • Bonafide products (OTC supplement) • Cooling options: Chillow Pillow, Ooler bed cooling system, etc. • Nonhormonal options: venlafaxine, gabapentin, oxybutynin, NKB antagonists **fezolinetant/VEOZAH 5/2023 FDA approva**l) • Psychosocial counseling and/or clinical hypnosis (EVIA 5 week ap- evidence based) • Sleep hygiene/CBT (Cognitive behavioral therapy)
Decreased sexual response	Medication review, ETOH use • Psychosocial counseling • Regular stimulation • CNS agents: Flibanserin or injection of Bremlanotide (Vyleesi) increases desire
Reduced overall sexual functioning and satisfaction	• Psychosocial counseling • Physical exercises or pelvic floor therapy • Schedule SEX; "nooner"
• **Intimacy or relationship concerns** • **Body image issues**	• Psychosocial counseling

Therapeutic Approach for Sexual Dysfunction Among Women



LOWEST DOSING !!
But higher cost >$300/mo

22

Case 3 – 28F with breast cancer

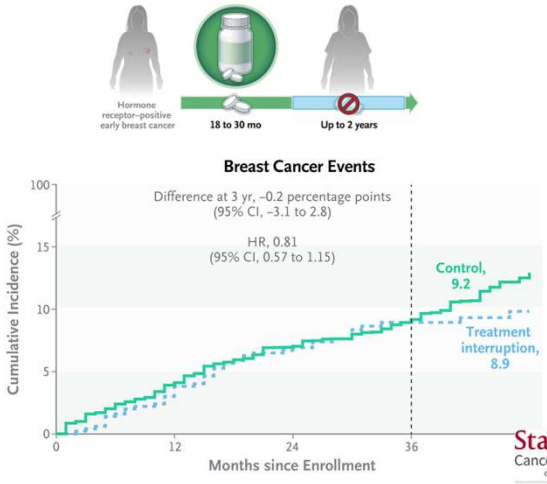
She works with a sexual health therapist and uses topical lubricant with improvement. Two years later, she would like to discuss whether she can attempt pregnancy.

Question 3: What would you recommend to this young woman on endocrine therapy for curable breast cancer who desires to have a biological child?

1. Present the data "gray zone" in context of patient's disease and preferences
2. Recommend that endocrine therapy <u>can</u> be safely interrupted
3. Recommend that endocrine therapy <u>cannot</u> be safely interrupted
4. Referral to AYA specialist
5. Referral to patient support group

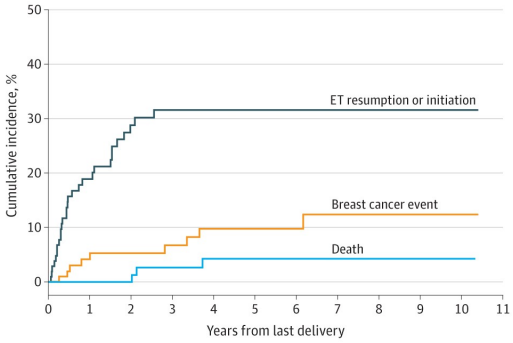
Attempting Pregnancy in Curable Breast Cancer

POSITIVE Trial: single arm study, compared to external control cohort



Partridge et al., NEJM, 2023

Low resumption of resuming endocrine therapy after a pause for pregnancy



Ransohoff et al., JAMA Oncology, 2025

Case 3 – 28F with breast cancer

After shared decision making, she decides to not attempt pregnancy and remains on endocrine therapy.

Take Home Messages

- **POSITIVE Trial**: At 3 years of follow-up, there is no increased risk of breast cancer when endocrine therapy is interrupted for pregnancy in this select population, but real-world data show that **resumption of endocrine therapy is rare** after pregnancy.
- "It is recommended that there be a discussion with the patient, initiated by a member of the health-care team, regarding sexual health and dysfunction resulting from cancer or its treatment." -- ASCO guidelines
- There are MULTI-disciplinary Interventions/options but you need to ask/respond/refer!

25

Case 4 – 56F with adrenal cortical carcinoma

Presents with abdominal bloating, found to have 17 cm mass arising from R adrenal gland. Biopsy confirms **adrenal cortical carcinoma.**

She is evaluated by surgical and medical oncology and recommended to start systemic therapy prior to consideration of surgical resection.

Develops new pulmonary metastases on **mitotane and hydrocortisone** and starts on EDP chemotherapy (etoposide, doxorubicin, cisplatin).

She has profound fatigue that has developed over several months and is now sleeping most of the day. Evaluated by endocrinology who notes no adrenal insufficiency or other endocrine explanation for the fatigue.

26

Case 4 – 56F with adrenal cortical carcinoma

Question 1: What would you recommend for this 56F with metastatic cancer on chemotherapy who is reporting profound fatigue?

1. Caffeine
2. Dexamethasone
3. Modafinil
4. Ginseng supplementation
5. Exercise
6. Light therapy
7. Cognitive behavioral therapy

ASCO Guidelines: Fatigue During Active Cancer Treatment

Strength of Recommendation	Quality of Evidence: Low	Quality of Evidence: Moderate
Strong Support		Resistance training, aerobic exercise, Tai chi, or qigong Cognitive behavioral therapy and mindfulness-based programs
Conditional Support	American ginseng at 2,000 mg daily	Psychoeducation
Conditional Against	Should not recommend L-carnitine	Should not routinely recommend psychostimulants (e.g., methylphenidate) or antidepressants (e.g., paroxetine)
Strong Against		Should not recommend wakefulness agents (e.g., modafinil)

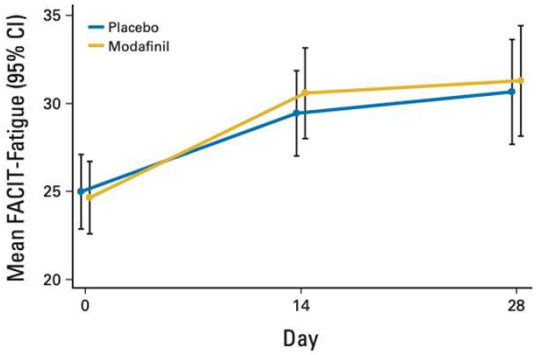
No recommendation for or against acupressure, CoQ10, minocycline, music therapy, progressive muscle relaxation, yoga

Adapted from Bower et al., JCO 2024

25th Multidisciplinary Management of Cancers: A Case-Based Approach

Pharmacologic options for cancer-related fatigue

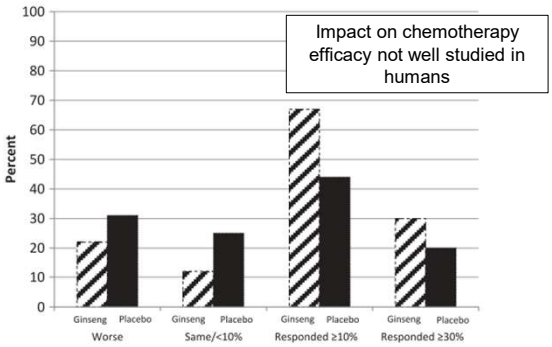
Modafinil = no change in fatigue



Randomized, double blind, placebo-controlled trial among patients with lung cancer

Spathis et al., JCO, 2014

American ginseng = favorable 8-week response



Randomized, double blind, placebo-controlled trial among patients with cancer who were undergoing or completed curative intent treatment

Barton et al., JNCI, 2013

29

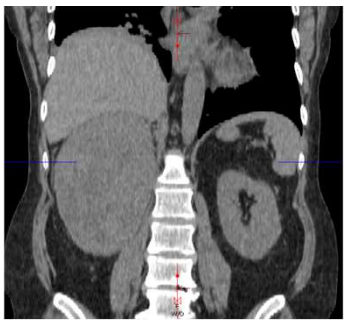
25th Multidisciplinary Management of Cancers: A Case-Based Approach

Case 4 – 56F with adrenal cortical carcinoma

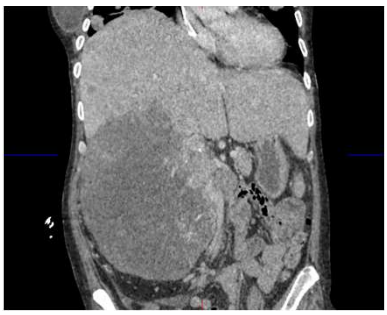
Patient starts herbal supplementation for her fatigue and abdominal discomfort.

Her next dose of chemotherapy is held for worsening functional status

She ultimately elects for hospice



Rapid growth



30

25th Multidisciplinary Management of Cancers: A Case-Based Approach

Supportive Oncology and Survivorship Panel

Cancer survivorship care includes evaluation for disease recurrence and secondary cancers; and management of chronic effects from cancer treatment, chronic medical conditions, and psychosocial conditions

Early RD referral is critical for patients at risk for cancer cachexia

Olanzapine can improve weight gain and appetite

There are multidisciplinary options for **sexual dysfunction**, but oncologists need to ask/respond/refer

Careful shared decision making is critical to support young women **regarding fertility and pregnancy**

Exercise and CBT have the strongest data for cancer-related fatigue

Multidisciplinary teams are critical to support our patients

31